102

102 Intermediate Care Facility for the Mentally Retarded (ICF-MR)

An Intermediate Care Facility for the Mentally Retarded (ICF-MR) is an institution that primarily provides the diagnosis, treatment or rehabilitation of the mentally retarded or persons with related conditions. ICF-MRs provide a protected residential setting, ongoing evaluations, planning, 24-hour supervision, and coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.

The policy provisions for ICF-MR facilities can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10.

102.1 Enrollment

EDS enrolls ICF-MR facilities and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a ICF-MR facility is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for ICF-related claims.

NOTE:
All eight characters are required when filing a claim.

ICF-MR facilities are assigned a provider type of 12 (Intermediate Care Facility). The valid specialty for ICF-MR facilities is Intermediate Care Facility (W4).

Enrollment Policy for ICF-MR Facilities

To participate in the Alabama Medicaid Program, ICF-MR facilities must meet the following requirements:

- Possess certification for Medicare Title XVIII
- Submit a letter to the Long Term Care Division requesting enrollment
- Submit a budget to the Provider Audit Division for the purpose of establishing a per diem rate
- Execute a Provider Agreement and a Nursing Facility/Patient Agreement with Medicaid

The Provider Agreement presents in detail the requirements imposed on each party to the agreement.

102.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Providers should refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

ICF-MRs must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

102.2.1 Therapeutic Visits

Payments to ICF-MR facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid will track the use of therapeutic leave through the claims processing system.

An ICF-MR must provide written notice to the resident and a family member or legal representative of the resident specifying the Medicaid policy upon a resident taking therapeutic leave and at the time of transfer of a resident to a hospital.

An ICF-MR must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility.

102.2.2 Review of Medicaid Residents

The Alabama Medicaid Agency or its designated agent will perform the following types of review of services provided to Medicaid residents in nursing facilities and in ICF-MR facilities:

- Pre-admission review on all Medicaid residents to assure the necessity and appropriateness of their admission and that a physician has certified the need
- The effectiveness of discharge planning
- Quality assessment and assurance

Annual physical examinations are required for ICF-MR residents.

102.2.3 Utilization Review

The Utilization Review function in the ICF-MR facilities is the responsibility of Medicaid or its designee.

The Utilization Review function in the ICF-MR facility is a facility-based review conducted by the Department of Mental Health/Mental Retardation (DMH/MR).

DMH/MR provides Medicaid with a written Utilization Review Plan. The Utilization Review Plan must include written description of who will perform the Utilization Review. At least one team member must be knowledgeable about the treatment of this type resident (Qualified Mental Retardation Professional).

The Utilization Review team **must not** include an individual who meets any of the following criteria:

- Is directly responsible for the care of the recipient whose case is being reviewed
- Is employed by the ICF-MR

The facility staff provides necessary administrative support to the review team.

The review team reviews each resident for the necessity of continued stay. Re-certifications are conducted 60 days from the date of the initial certification; 180 days from the date of the initial certification; 12 months from the date of the initial certification; 18 months from the date of the initial certification; 24 months from the date of the initial certification; and every 12 months thereafter.

DMH/MR provides Medicaid with a semi-annual report of utilization reviews carried out in the ICF-MR facilities.

102.2.4 Resident Medical Evaluation

The admitting and attending physician must certify the necessity for admission of a resident to an intermediate care facility and make a comprehensive medical evaluation. The facility maintains this evaluation as part of the resident's permanent record.

Each Medicaid resident in an intermediate care facility must have a written medical plan of care established by his physician. The plan of care must be periodically reviewed and evaluated by the physician and other personnel involved in the individual's care.

102.2.5 Periods of Entitlement

The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

102.2.6 Resident Records

Medicaid monitors the admission and discharge system and maintains a record for each active patient in the ICF-MR.

102.3 Prior Authorization and Referral Requirements

ICF-MR residents are exempt from the Patient 1st program. No referrals are required for billing.

102.3.1 ICF-MR Applications

To obtain medical need for admission or continued care in an ICF-MR, the ICF-MR facility must submit an application packet within 60 days from the date Medicaid coverage is sought.

The application packet contains the following:

- A fully completed written application form XIX-LTC-18
- The resident's physical history
- The resident's psychological history
- The resident's interim rehabilitation plan
- A social evaluation of the resident

Before the ICF-MR may admit an individual, it must determine that his or her needs can be met. The interdisciplinary professional team must do the following:

- Conduct a comprehensive evaluation of the individual, covering physical, emotional, social and cognitive factors.
- Define the individual's need for service without regard to the availability of these services.
- Review all available and applicable programs of care, treatment, and training and record its findings.

If the ICF-MR determines that admission is not the best plan but that the individual must be admitted, it must clearly acknowledge that admission is inappropriate and actively explore alternatives for the individual. An otherwise eligible recipient or the recipient's sponsor cannot be billed when the ICF-MR fails to submit all forms in a timely manner.

102.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by ICF-MR facilities.

102.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims for general claims filing information and instructions.

102.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ICF-MR facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

102.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

102.5.3 Covered Revenue Codes

Claims for ICF-MR facilities are limited to the following revenue codes:

Code	*Description*
101	All inclusive room & board
184	Intermediate Care Facility charge

102.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

102.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

102.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Deleted: ~~Managed Care, Appendix D~~

Added: Patient 1st, Chapter 39

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Outpatient Hospital/ASC Procedure List	Appendix I
Patient 1st	Chapter 39
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N